STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health and Environment
Committee on Commerce
United States House of Representatives

RE: Medicare Provider Service Organizations

March 19, 1997

My name is Richard F. Corlin, MD. I am a gastroenterologist in private practice in Santa Monica, California. I also serve as Speaker of the American Medical Association (AMA) House of Delegates. On behalf of the AMA, I appreciate the opportunity to testify before this Subcommittee concerning the need for promoting greater patient choice of health plans in the marketplace.

Toward this goal, we commend you, Mr. Chairman, for holding this hearing on the need for provider sponsored organizations (PSOs). We look forward to working with this Subcommittee to create the framework necessary to stimulate the formation of PSOs dedicated to the delivery of high quality, affordable patient care.

Fulfilling the Promise of Antitrust Relief for Physician Networks

The market for health care finance and delivery is undergoing substantial change. It would be optimal if this transformation resulted in a greater choice of health plans for patients, including those formed by physicians, hospitals, or other health care providers to compete with insurance companies. However, regulatory obstacles block the way.

Last year, we came to Congress seeking relief from one of those obstacles -- antitrust enforcement policies that chilled the development of physician-owned health care delivery networks and health plans. In response, House Judiciary Committee Chairman Henry Hyde introduced H.R. 2925, legislation that would allow physician networks the same antitrust treatment as joint ventures in other industries. The bill gained a formidable list of cosponsors -- over 150 in all. Ultimately, the Federal Trade Commission and the Department of Justice agreed that changes were needed, and despite massive opposition from the insurance companies, issued new enforcement guidelines similar in application to Chairman Hyde's legislation. According to those agencies, the goal of the guidelines is to "ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."

We are here today to seek your help in securing the remaining tools needed to promote the development of PSOs and Provider Service Networks (PSNs). In so doing, Congress can improve health care quality by putting physicians and other qualified health care providers back in charge of medical decision making.

The Case for PSOs

Many physician networks have been successful in reducing health care costs while maintaining or enhancing quality. For example, a recent study in the *New England Journal of Medicine*, by James C. Robinson and Lawrence P. Casalino, reported on the cost performance of six physician-owned medical groups in California that accepted global capitation arrangements (which means that the physicians

accepted the risk that patients would need hospital services as well as physician services). It found that hospital use by these groups in 1994 ranged from 120 to 149 days per 1,000 non-Medicare members, and from 643 to 936 days per 1,000 Medicare members. In contrast, the mean number of 1993 hospital days per 1,000 non-Medicare members for commercial health maintenance organizations in California was 232 days, and for Medicare members was 1,337. This is especially significant because hospital use accounts for by far the highest percentage of health care expenditures, and the primary source of savings achieved by managed care health plans has been reductions in hospital usage.

Underlying these developments, and making them possible, are changes in the way that physicians are approaching medical care. First, allopathic medicine is undergoing a period of comprehensive reassessment to determine what health care services are in fact beneficial to patients. Those found not to be effective are being discarded. Second, physicians are evaluating the best ways to coordinate the services of multiple providers used to treat an illness or injury. The object is to eliminate inefficient uses of resources and to improve the quality of the outcome of the treatment process.

This process of assessment and coordination is handled by groups of physicians who evaluate data about their performance, including cost and outcome, and then investigate the care giving sequence. They determine whether all services provided in the sequence were effective, and whether the services were provided in the most efficient way possible. Some have called this process "total quality improvement." This process is best handled by the physicians involved in providing the care. It is not possible for insurers or other intermediaries to engage in this process effectively, since they are not involved in the direct provision of medical care. They are too remote from actual health care delivery.

Insurance companies managed by non-physicians can, and have, reduced health care costs by placing

restrictions on hospital stays by their beneficiaries. They enforce these limits with "preauthorization procedures," which require physicians to obtain approval for all hospitalizations from the insurance company. Insurers have done this by using non-physician personnel to enforce the limits during preauthorization procedures. These personnel usually communicate with physicians by telephone, fax or computer, and are often hundreds or thousands of miles away from where the care is being provided.

These limits do little to improve the quality of care provided and, more importantly, there is a limit on the extent to which these restrictions can reduce costs without compromising quality. Once hospital stays are reduced to the levels contained in the limits, there is little more that the insurer can do.

In order to achieve additional savings while actually improving quality, it is necessary for physicians to gather data about the exact services provided to treat an illness or injury, how the services were provided, the cost, and the outcome. By engaging in a critical review of the details of the process, they can determine the best services to treat an illness or injury, thereby improving quality, and the most efficient provision of these services, thereby reducing costs. This is a much different process than placing arbitrary limits on hospital stays or denying coverage for various kinds of treatment.

That is why PSOs and PSNs are so important to the future of health care in our country. They are health care delivery systems owned by physicians and other health care providers that are designed to maximize cost savings and quality by engaging in this process. Their development is essential to reach the next level of cost savings while enhancing quality of care.

In general, PSOs are defined as health care delivery systems owned and operated by physicians and/or other health care providers with the ability to provide a substantial part of the Medicare benefit package

pursuant to risk sharing arrangements. A PSN is a provider network that does not have the capacity to deliver a substantial portion of Medicare benefits, but which can contract with PSOs or other eligible organizations to deliver care pursuant to risk sharing arrangements

Physicians and other providers are eager to develop PSOs and PSNs. We are concerned about third party intrusion into the patient-physician relationship and, ultimately, medical decision making. We are troubled about judgments being made about the care of individual patients pursuant to restrictions imposed from remote sites by non-physicians. Physicians and other health care providers believe that we can not only reduce costs but lead medicine into a new era of improved quality if we can take back the reins.

The AMA is pleased that Congress acknowledged the importance of PSOs and PSNs by including provisions meant to facilitate their development in the Balanced Budget Act of 1995, which was subsequently vetoed by President Clinton.

In addition, we note the introduction of the "Medicare Provider-Sponsored Organization Act of 1997" (H.R. 475) by Representatives Greenwood and Stenholm. This legislation would allow PSOs to provide benefits to Medicare beneficiaries without unnecessary insurance middleman. The legislation would establish standards that qualified PSOs must meet in order to serve Medicare patients such as solvency requirements, licensing requirements, and enhanced quality standards and consumer protections. We commend the sponsors of this legislation for moving the PSO debate forward this year in the House. We look forward to working with Representatives Greenwood and Stenholm to ensure that the full potential of physician and other health care provider-led networks is realized.

The AMA's Vision of PSOs

The AMA's plan to transform Medicare is based on expanding the choice of health plans available to Medicare beneficiaries, including PSOs and other eligible organizations that partner with PSNs. Congressional action is essential to fostering the formation of these entities. The AMA believes that PSO legislation should have certain characteristics.

First, the legislation should allow as much flexibility as possible to stimulate innovation in the delivery of patient care. Legislation should not favor any one PSO model type or any health care provider group over another in the ownership and management structure of a PSO. The market should determine what PSO models and ownership structures are the most successful.

With regard to flexibility, the AMA is concerned that H.R. 475 would favor the hospital-owned or physician\hospital organization (PHO) model to the exclusion of others. The AMA believes that physician networks and large group practices should also be able to lead the formation of PSOs. This is important to the public because it is ultimately physicians who must engage in the process of evaluating medical care to improve its quality and reduce its cost. Again, we believe these decisions should be left to the market to determine.

Indeed, the importance of physician leadership is borne out by research. A recent study led by Stephen M. Shortell, a Professor of Health Services Management at Northwestern University, found that health care delivery systems which had significant "physician-system integration" performed better than those that did not. The author defined physician system integration as the degree to which physicians use the system, including being involved in the planning, management, and governance of the system. The study also found that the higher the degree of physician-system integration, the greater the delivery system's inpatient productivity. The study noted that "(i)t is simply not possible to achieve any measurable level of clinical

integration for patients without a close relationship of physicians with an organized delivery system."

Second, PSO legislation should contain tough consumer protection standards. Such standards should include requirements that PSOs use continuous quality improvement methods, evaluate continuity of care, monitor the over- or under-provision of care, provide information to help beneficiaries choose plans and require coordination of utilization review with a PSO's quality program.

The AMA has long been committed to protection of the patient. The AMA has undertaken a number of unprecedented efforts in the area of quality assessment and physician performance. As you may be aware, the AMA last year approved the development of an accreditation program for physicians. Subsequently named the American Medical Accreditation Program (AMAP), the program is designed to establish national standards of physician performance.

Recently, AMAP took its first step toward implementation and announced that it is ready to approve self-assessment programs for inclusion in the AMAP program. As a result, AMAP has invited those entities with self-assessment programs to submit them for review. In addition, the AMA is unveiling this week our perspective on a set of health plan characteristics that we believe to be essential to the operation of a quality managed health care plan. The document, entitled "Essential Characteristics of a Quality Health Plan," describes what makes for "good" managed care, including patient rights, continuous quality improvement, accreditation and respect for the patient-physician relationship. We look forward to working with the Congress on these quality improvement initiatives.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain anti-fraud and abuse laws and self-referral laws. These laws were designed to

regulate the conduct of physicians in independent practice under traditional fee-for-service medicine, and they were intended to prevent the provision of unnecessary care. The laws make sense for the regulation of fee-for-service arrangements where the physician may have an incentive to provide unnecessary care. However, they have no purpose in the regulation of networks that are designed to reduce the provision of unnecessary care, especially when the networks are involved in risk sharing arrangements in which physicians have an incentive to reduce unnecessary care.

Another regulatory obstacle is pension regulations pursuant to Section 414(m) of the IRS Code. They may require that physicians who form certain kinds of networks aggregate their pensions and comply with the nondiscrimination provisions. Those provisions could have a material adverse effect on the retirement plans set up by individual physicians. This could discourage physicians from developing networks.

Fourth, solvency standards should reflect the unique characteristics of PSOs. In spite of the potential benefits of having physicians direct health plans, in 1994 only 6.4% of health maintenance organizations (HMOs) were owned by physicians, physician medical groups, physician hospital organizations (PHOs), and state medical societies combined. This is due in part to the chilling effect of state insurance and HMO regulations that fail to account for the distinctions between provider networks that deliver services directly and traditional HMOs and insurers that purchase health care services and resell them.

There are dramatic differences between provider organizations that assume risk and insurance companies. Provider organizations exist for the primary purpose of delivering health care services to patients. To the extent that they enter into risk sharing arrangements, they do so for the primary purpose of delivering health care. The assets of providers that enter risk sharing arrangements are concentrated in health care delivery. A way to better understand this concept is to consider the analogy of repair warranties issued by car manufacturers. These warranties involve the assumption of risk, and are a significant financial

commitment. However, car manufacturers offer them for the primary purpose of selling cars, and the assets of car companies are concentrated in car manufacturing.

In contrast, the primary purpose of insurance companies is to profit by underwriting risk. Insurance companies do not deliver health care services. They buy them to the extent necessary to satisfy claims. Insurers seek to profit by investing the spread between premium income and claims in financial securities such as stocks, bonds, mortgages, and other investments. Their assets are concentrated in such liquid securities, not in health care delivery. However, the regulations of most states, including solvency standards, statutory accounting principles, and financial reporting requirements, are designed for insurance companies, not provider networks that assume risk. They typically require that insurers maintain a substantial amount of liquid assets and maintain a financial management system that identifies those liquid assets for insurance regulators. This suits the business of insurance well because insurers typically maintain a substantial amount of liquid assets in the ordinary course of their business, and if they do not, then they are likely to be in danger of becoming insolvent.

State regulations do not fit the operations of health care providers. Health care providers normally do not maintain substantial liquid assets. However, that does not mean that they are in danger of becoming insolvent. Their assets are concentrated in health care delivery, and they have the capacity to deliver services for which they assume risk. That does not mean that provider networks can sustain substantial and unexpected catastrophic losses, but they can sustain themselves longer without liquid reserves because of their health care delivery assets.

Because of this, and because of the particular demands of the Medicare program for uniformity in administration and operation across the United States, PSOs should be subject to federally-developed

solvency standards which recognize their unique differences. Solvency standards should recognize the value of assets used in health care delivery as well as ways of responsibly handling risk such as reinsurance, capitation, and fee withholds. PSOs are critical to the success of a reformed Medicare system based on free market competition; it is essential that they not be forced into inappropriate state regulatory structures that would compel them to become HMOs, thereby eliminating them as a separate option under Medicare.

By regulating PSOs at the federal level, Congress will follow its precedent of encouraging new ventures that stimulate competition and provide efficiencies. A notable example is the Federal HMO Act of 1973 that was intended to, and did, facilitate the development of HMOs as a means of increasing access and lowering costs. At the time, HMOs faced legal barriers including state solvency requirements viewed as not recognizing their particular characteristics. To remedy the barriers, the Act created a federal regulatory scheme for HMOs that preempted state laws that interfered with their formation and operation. These provisions included grants and loan guarantees for the formation of new HMOs, solvency requirements different from those of other health plans, and a mandate that employers offer HMOs available in their geographic locations as a health benefit option to their employees. In comparison, the provisions to facilitate PSOs are modest in scope.

Finally, any legislative proposal considered by the House should also include the creation of PSNs. PSNs, owned and operated by physicians and other health care providers, could contract with PSOs to deliver health care services.

Physicians usually begin the process of managing care with a PSN, because the development of skills and capacity necessary to operate a PSO takes time and experience. These networks typically begin with simple arrangements that are easy to manage, such as discounted fee-for-service networks, and then

enter into risk sharing arrangements that require greater managerial sophistication. If the network is successful and is able to manage greater and greater amounts of risk, meaning that larger amounts of services and patients are included in these arrangements, the network could evolve into a provider-owned health plan such as a PSO. Therefore, PSN development is important to the creation of PSOs.

Setting the Record Straight

Fear of competition has caused the insurance industry to vehemently oppose any PSO legislation. Since most insurance companies are corporate profit-making entities, first and foremost, it is to their advantage to keep physicians, hospitals and others out of the market. Insurers argue that different solvency standards for provider networks will put patients at financial risk.

The reality is that insurance companies are making the same arguments against the House provisions for the regulation of provider networks that they used in the 1970s to oppose HMO laws. HMOs argued successfully that they represented a different product and should be evaluated by different standards. Established insurers will maintain an unfair competitive advantage if provider networks are required to meet the same standards as insurance companies. Patients will ultimately bear the unnecessary cost of excessive capital requirements. Physician and hospital networks are different than insurance companies and commercial HMOs that operate as third party payers. PSOs must and should be required to meet high standards that guarantee consumer protection and quality assurance. But they should not be treated as something they are not: insurance companies.

The insurers also argue that PSOs would lack consumer protections without state licensing. The reality is that pending legislation before the House and Senate would apply current Medicare consumer protections to PSOs, such as grievance and appeals processes and enrollment and

marketing standards. Enhanced quality standards are also required by the legislation, including continuous quality improvement methods and evaluation of continuity of care.

Finally, the insurers argue that state insurance regulation will better protect consumers. The truth is that insurance companies have a checkered history on patient protection. Several plans have either suffered unfavorable court rulings or have been forced to refund millions of dollars bilked from beneficiaries. Tax-favored plans in certain states have overcharged patients by failing to pass on discounted rates and have collected excessive patient co-payments.

Conclusion

The case for PSOs and PSNs is compelling. Yet, provider networks will be unable to present a meaningful alternative to insurance company plans, and, thereby, improve the competitive process, if they are not permitted to operate effectively. The encouragement of these networks subject to federal regulation will benefit both the Medicare Program and Medicare beneficiaries. Mr. Chairman, the AMA looks forward to working with you and the Subcommittee to ensure passage by the Congress of meaningful PSO and PSN legislation. We thank you for the opportunity to share our thoughts and concerns.